TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Universal DME

**Respondent Name**
New Hampshire Insurance Co

**MFDR Tracking Number**
M4-16-3558-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
July 29, 2016

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Per EOB it stated that this bill was denied as a duplicate, which is a billing error since we only turned it in once and then the second time was when we sent an appeal."

**Amount in Dispute:** $525.60

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** The Division placed a copy of an acknowledgement of receipt of the medical fee dispute resolution on August 8, 2016. Texas Administrative Code §133.307 (d) (1) states, "Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." As no response was received this dispute will be reviewed based on available information.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 21 – 2016 through April 3, 2016 | E0935, RR | $491.40 | $439.95 |
| March 21, 2016 | E0188 | $34.20 | |
| | Total | $525.60 | |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 1 – Procedure/service was partially or fully furnished by another provider
   - 2 – This bill is denied as a duplicate
   - 3 – A reduction was made because a different provider has billed for the exact services on a previous bill

**Issues**

1. Are the insurance carrier's reasons for reduction of payment supported?
2. What is the rule applicable to reimbursement?
3. Did the requestor support services billed?
4. Is the requestor entitled to additional reimbursement?

**Findings**

1. This claim involves the rental of code E0935, RR – "Continuous passive motion exercise device for use on knee only." With a date span from March 21, 2016 – April 3, 2016 and purchase of (1) E0188 – "Synthetic sheepskin pad" rendered March 21, 2016.

   The insurance carrier denied the disputed services with claim adjustment reason code 1 – "Procedure/service was partially or fully furnished by another provider" and 2 – "This bill was denied as a duplicate."

   While all submitted documentation was reviewed, insufficient documentation was found to support the denial reasons. The respondent did not respond to the DWC60 request or submit documentation to support the denials. Therefore, the services in dispute will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code §134.203(a)(5) states in pertinent part,

   > "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   Review of the CMS Medicare Claims Processing Manual, www.cms.hhs.gov, Chapter 20, Section 30.2.1, states in pertinent part, *Daily Payment for Continuous Passive Motion (CPM) Devices)*

   > *…payment for each day that the device is used in the patient's home*

   Review of the submitted medical claim finds a date span from March 21, 2016 – April 3, 2016, for a total of 14 days or units.

   Based on the applicable Medicare payment policy, the total "daily" rental of 14 days will be considered per applicable fee guideline.

   28 Texas Administrative Code §134.203 (d) states,

   > The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
   >
   > > 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

   Review of the 2016 – 1st Quarter Texas DMEPOS Fee Schedule finds the allowable for E0935, RR is $25.14 per day.

   This fee schedule amount ($25.14) x 14 days = $351.96 multiplied by 125% = $439.95.

3. The requestor submitted code E0188 on the medical claim for date of service March 21, 2016. The narrative description of E0188 is "Synthetic sheepskin pad." Review of the submitted delivery ticket dated March 11,

2016 and signed by the claimant on March 21, 2016, shows "Qty" 1 – "Purchase E0188-20533/CPM Kit knee Optiflex."

28 Texas Administrative Code §133.20 (c) states,

> A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills.

Based on review of the submitted documentation insufficient evidence was found to support that the code E0188 submitted on the medical claim was the correct code detailed on the "Delivery Ticket," "CPM/Kit knee Optiflex" As a result, payment cannot be recommended.

4. The total allowable reimbursement is $439.95. The amount paid by the carrier was $0.00. The remaining balance of $439.95 is due to the requestor.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $439.95.

## *ORDER*

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $439.95, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | September 29, 2016<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.